PRINTED: 02/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085035	A. BUILDING _____ B. WING _____	C 02/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DELAWARE HOSPITAL F/T CHRONICALLY ILL (DHCI)	100 SUNNYSIDE ROAD SMYRNA, DE 19977

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual survey and complaint visit was conducted at the facility from January 27, 2010 through February 12, 2010. The deficiencies contained in this survey are based on observations, interviews, review of residents' clinical records, and review of other facility documentation as indicated. The survey sample included sixteen (16) admission and thirty (30) census residents in Stage I. The Stage II sample included twenty-five (25) residents.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of	F 157	**F157 NOTIFICATION OF CHANGES (#1)** A. Foley was inserted the following morning. Physician was notified on rounds. B. All residents have the potential to be affected by this practice. C. Policy #319 'Physician Notification of Change' will be reviewed and revised as needed to include notifying physician whenever a procedure cannot be carried out. Inservicing will be completed by April 30, 2010. Supervisor will be notified for orders not able to be carried out and will review the physician's book during shift rounds for urgency. D. Supervisors and charge nurse will monitor the 24-hour report and the physician's book during each shift.	4/30/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheryl A Hollis NHA — TITLE: Acting Director DHCI — (X6) DATE: 03/15/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined for two (R215 and R31) out of 25 sampled residents that the facility failed to consult with the resident's physician of a significant change. The facility failed to notify the R215's physician when an order for an urinary catheter could not be carried out. In addition, the facility failed to notify R31's physician of a new onset of right shoulder pain. Findings include: 1. On 7/30/09 R215 had returned from the hospital post surgical flap revision to the sacral area. There was a physician's order to insert a Foley urinary catheter. The 3-11 nurse E3 was unable to get the catheter inserted. A second nurse was unable to get the catheter inserted. Although E3 passed this on in report to the next shift and left a note in the physician's book for the next morning, the nurse failed to consult with the physician about not being able to place the Foley catheter. The catheter was not placed until the next morning. 2. Cross refer F309, example 1. R31 had a new onset of right shoulder pain beginning in December 2009 as documented on the Pain Medication Administration Record (MAR). Record review lacked evidence that the attending physician (E19) was notified of this new	F 157	**F157 NOTIFICATION OF CHANGES (#2)** A. Physician was notified on 2/12/10 of right shoulder pain. An x-ray was ordered and Banalg was ordered QID x 1 week for pain relief. B. All residents have the potential to be affected by this practice. C. Policy #319 'Physician Notification of Change' will be reviewed and revised as needed to include notifying physician when resident reports new onset of pain. Inservicing will be completed by April 30, 2010. IDCC worksheet will be reviewed and revised to include any new onset of pain. Policy #309 will be reviewed and revised as needed to include assessing pain for each resident q shift. Inservicing will be completed by April 30, 2010. D. MAR will be reviewed by head nurse or designee for acceptable level of pain. If above acceptable level, physician will be notified. CQI will randomly audit for same.	4/30/10

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F 157	Continued From page 2 onset of pain. An interview with E19 on 2/15/10 at approximately 9 AM confirmed that she was not notified regarding R31's complaints of pain in the right shoulder until this survey.	F 157		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the	F 164	**F164 PRIVACY AND CONFIDENTIALITY (#1)** A. Privacy curtain was immediately pulled for Resident #54. B. All residents have the potential to be affected by this practice. C. Head nurse or designee will inservice staff regarding the importance of maintaining the confidentiality, dignity and privacy D. Random unit rounds will be conducted during each shift by the head nurse or designee as well as the nursing supervisors.	4/30/10

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F 164	Continued From page 3 facility failed to ensure the personal privacy of three (R54, R30, and R43) out of 25 sampled residents. R54 was seen sitting on the toilet from hallway. R30 and R43 had isolation signs posted at their door that indicated the location of their infection. Findings include: 1.On 2/1/10 at 11:52 AM R54 was taken to the bathroom located off the main hallway. Aides E4 and E5 were in the bathroom with residents in at least two stalls. The door to the bathroom was wide open and the curtain to R54's stall was not fully closed. The resident could be viewed on the toilet from the hallway for several minutes while the resident sat on the toilet. 2. Observations on 1/27/10, 1/28/10, and 1/29/10 revealed a contact precaution sign with the word, "Urine" circled, posted outside of R30's room. Review of the "24 hour report sheet" revealed that R30 was on "contact" precautions for ESBL (Extended Spectrum Beta-Lactamase - bacteria that produce enzymes that break down some antibiotics rendering the antibiotics useless) in the urine. 3. Observations on 1/27/10, 1/28/10, and 1/29/10 revealed a contact precaution sign with the words, "Oral Secretions" circled, outside of R43's room. Review of the "24 hour report sheet" revealed that R43 was on "contact" precautions for MRSA (Methicillin Resistant Staphylococcus Aureus - bacteria that is highly resistant to different types of antibiotics) in the sputum. During an interview on 2/2/10, two nurses, E10 and E11, stated that the signs outside R30's and	F 164	**F164 PRIVACY AND CONFIDENTIALITY (#2 & #3)** A. Signs were removed immediately from resident's room and discarded so not to be used again in facility. B. A sweep of all residents on Contact Precautions was conducted to ensure that other Contact Precaution signs were not circled indicating specifics about their diagnosis. C. Contact Precaution Policy will be reviewed for clarity of procedures. Education will be completed on Personal Privacy/Confidentiality of records and how it relates to residents when they are placed on "Special Precautions –Contact Precautions" by April 30, 2010. D. Infection Control Nurse or designee will visit all residents initially placed on Special Precautions and ensure proper Infection Control processes and Special Precautions procedures are in place. Routine rounds will be conducted on all Residents on Special Precautions. Random audits will be conducted or residents placed on Special Precautions.	4/30/10

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F 164	Continued From page 4 R43's rooms were changed on 1/29/10 after E12, Quality Assurance, had informed them not to circle the signs. They stated that the isolation signs should not contain a resident's name or indicate what precautions are in place. This information was provided in shift report and documented on the "24 hour report sheet." Both nurses acknowledged that posting such information violates the resident's privacy and is not in accordance with HIPPA regulations. The facility failed to maintain R30's and R43's privacy when they initially posted this information outside their rooms.	F 164		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	**F 225 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS** A. Upon receiving the incident report detailing the information pertaining to the allegation of neglect in relation to R137, the QA Department immediately reported the incident as a PM-46 to LTCRP and an investigation was initiated. B. PM-46 training is conducted annually and reporting of PM-46 incidents is covered during the training session. In addition, during November and December of 2009, a series of training sessions were held specifically focused on the Incident Reporting process with a strong emphasis on the importance of immediate notification. The incident report training will be held annually or more often as needed and during orientation of new employees in concert with the PM46 instruction.	

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F 225	Continued From page 5 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that for one (R137) out of 25 sampled residents the facility failed to immediately report an allegation of neglect. Findings. 1. Nurse E6 reported on 7/31/09 that at 9 AM she found R137 with his clinitron bed off, JP drain not to negative pressure and his Foley catheter was not in causing his sacral dressing to be wet with urine. An incident report was completed, however, this allegation of neglect was not immediately reported to the state agency. The state agency was notified on 8/5/09. An interview on 2/12/10 with the Risk Manager (E7) revealed that the incident report did not get to the quality assurance department until 8/5/09 for reporting. This is a repeat deficiency from the annual surveys ending 4/8/09, 5/13/08 and 7/5/07.	F 225	C. Nurse E6 was reminded on 7/31/09 of her responsibility to report any incident that may meet PM-46 standards and the importance of turning in incident reports immediately. D. To remedy the potential of incidents in the future an incident report committee was formed to address improving DHCI's incident reporting process and to improve staff involvement in immediate reporting. The committee met on January of 2010 and is scheduled meet monthly up to May 14, 2010. Furthermore, a meeting will be scheduled with all department heads no later than April 16, 2010 to discuss and relay concerns to be shared with related staff. In addition, Quality Assurance monitors the 24 hour reports and Incident Reports on a daily basis. Upon discovery of an incident that was not reported, they will follow-up to ensure an Incident Report is written, and the process is followed for PM-46 reporting.	4/16/10
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES	F 248		

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F 248	Continued From page 6 The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined that the facility failed to have an ongoing program of activities that met the needs and interests of one (R194) out of 25 sampled residents. The facility failed to have a system that ensured R194's activity needs and interests were met. Findings include: R194 was admitted to the facility on 4/13/09. Initial Activity Assessment form dated 8/22/09 indicated current activity pursuit patterns included country music, newspaper, game TV shows, football/baseball, and movies. Review of the MDS 14 day assessment dated 4/19/09 and most recent quarterly MDS dated 10/14/09 revealed that R194 was severely impaired for cognitive impairment and spent on average 1/3 to 2/3 of his time in activity pursuits. Review of R194's Activities attendance for January 2010 revealed a total of ten documented activities to include friendly visits (FV, 2 occurrence), talking/conversing with resident (3 occurrence), canteen (2 occurrence), watching TV (1 occurrence), music (1 occurrence), and exercise offered but refused (1 occurrence). For February 1-9, 2010, total of four documented activities for two days to include FV (2	F 248	**F248: ACTIVITIES MEET INTERESTS/NEEDS OF EACH RESIDENT.** A. Resident 194's Care Plan was immediately reviewed and the annual Activity Assessment, which is due in April, was completed and updated to reflect the resident's current capabilities, interests, and needs. To assure that Nursing Staff on the units are aware of the Activity Plan, the Resident Profile was revised and now allows for an "Activity Interest" section which summarizes Resident 194's Activity interests. Lastly, Activity Staff have been re-inserviced on the best practices to follow to capture as many resident interactions and activity participation units on their monthly Activity documentation form. Completion Date: March 11, 2010 B. All residents have the potential to be affected by the same deficient practices. Therefore, all Residents' Profiles will be revised to include a Residents' Interest section which summarizes their Activity Care Plan information. Activities staff will write the summaries and share with the appropriate staff for completion. In addition, the Activity Summaries will be posted on the inside of each Residents' closet for review by staff to increase their accessibility and knowledge of each Resident's Activity Plan. Completion Date: April 30, 2010	3/11/10 4/30/10

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F 248	Continued From page 7 occurrence), talking/conversing with resident (1 occurrence), and music (1 occurrence). R194 was observed throughout the survey sitting in the Q foam chair by the nursing station with no meaningful activity. Interview with R194's assigned CNA (E20) on 2/4/10 at 10:46 AM revealed that R194 is not able to communicate his activity interest and that the assigned activity staff usually transports R194 to an activity. E20 further related that R194's activity interests are not on the CNAs Resident Profile document. An additional interview with R194's other assigned CNA (E21) on 2/5/10 at 10:29 AM revealed that R194 enjoys sitting around the nursing station and likes to drink coke. E21 relayed that for the CNAs, there is no source that they can review to ascertain resident activity interest. An interview with the Activity Therapist (E23) on 2/5/10 at approximately 11 AM revealed that the primary source would be to review the activity care plan and/or the assessment in the resident's clinical record. Repeat observation of R194 on 2/5/10 at 11 AM revealed a "Sports Illustrated" magazine was provided to the resident. Above findings reviewed with administration on 2/12/10 at approximately 2:30 PM.	F 248	C. To assure that the Resident Profiles are updated to coincide with the Care Plans, the Activity Interest section will be completed and reviewed at each Resident's IDCC Meeting. It will be the Activities Staff responsibility to assure all updates have been addressed in each Care Plan and Activity Summaries are posted in Resident Rooms. D. Monitoring the completion of Resident Profile Forms and Resident Room Activity Summaries will be the responsibility of the Activity Therapy Department to report to the Quality Assurance Committee. Under the direction of the Director of Rehabilitation and the Activities Coordinator each quarter, random audits will be performed and documented. All findings will be reported at each quarterly meeting to assure compliance.	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	F 253	A. 1. Work order request for Rm. 253 to repair paint damages around the window area has been submitted. Actual repair work follows. **Completion Date: 3/20/10** The missing drawer was replaced. **Completion Date: 2/15/10**	

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F 253	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations made in the resident rooms throughout the survey, it was determined that the facility failed to provide maintenance services necessary to maintain an orderly and comfortable interior. Findings include: 1. Room #523 was observed with paint scratched, missing and scuffed around the window area. One out of five drawer fronts on the chest of drawers was missing. 2. The right side, bed side stand in room #266 and the bed side stand in room #260 had veneer damage. The top surface edge was missing the veneer covering and could not be cleaned/sanitized properly. Pieces of the top surface edge were missing on the stand in room #260. Room #306 had two bed side stands with top surface veneer damage. 3.Rooms #366 and #308 had wall plaster damage at the bed, head board area. 4. Room #304 had wall damage adjacent to the closet area.	F 253	2. The bedside stands in Rooms 266, 260, and 306 (total of four) will be replaced. Completion Date: **3/10/10** The four bedside stands from Room 266, 260, and 306 will be evaluated by Facility operations for repair or replacement. **Completion Date: 3/20/10** 3. Work order request for wall plaster and paint damages in Rooms 308 and 366 has been submitted. Actual repair work follows. **Completion Date: 3/20/10** 4. Work order request to repair wall damage in Room 304 has been submitted. Actual repair works follows. **Completion Date: 3/20/10** **B.** A sweep of the Nursing Units where problem areas has been identified was completed on 3/8/10. Steps are being taken to repair or replace damaged night stands. Steps are also being taken to repair wall paint or plaster damages in resident rooms. **Completion Date : 3/20/10** **C.** Charge Nurses will submit work orders, via e-mail, to Facility Operations as repair needs are identified in their respective Nursing Unit. **Completion Date: On-going** **D.** A Risk Manager, of Quality Assurance, will perform random on-going inspections of resident rooms to ensure compliance under this requirement. **Completion Date: On-going**	3/20/10
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280		

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F 280	Continued From page 9 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that for one (R104) out of 25 sampled residents the facility failed to review and revise the care plan when care needs changed. Findings include: 1. Cross refer F323. R104 had a history of falls including two from the bed on 11/15/09 and 12/23/09. The resident had a physician's order for the use of an ultra low bed. This approach of a low bed to reduce injury from falls was not on the nurses or the aides care plans for this resident. The low bed was not in place during the survey. An interview on 2/9/10 with the unit manager (E9) confirmed that the ultra low bed was not currently in use and not part of the care plan.	F 280	**F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP** A. Ultra low bed was provided for Resident #104 and the care plan was updated to reflect this. B. All residents have the potential to be affected by this practice. C. IDCC worksheet will be reviewed and revised to include interventions to prevent falls (i.e. mats, alarms, ultra low or low bed). Policy #1704 'Medication/Treatment Orders: Transcribing and Discontinuing' will be reviewed and revised as needed to ensure physician's orders are addressed in the care plan as needed. D. Interim Physician's orders will be reviewed daily to ensure all new orders are addressed and care planned for appropriately. Recheck physician's orders will be reviewed	4/30/10
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interviews and policy review, it was determined that the facility failed to provide services that met professional standards of quality for three (R213, R104, and R31) out of 25 sampled residents. The facility failed to complete neurological assessments after unwitnessed falls experienced by R213 and R104. The facility failed to provide a pain management program that met professional standards of quality for R31. Findings include: 1. R213 was a resident on the secured dementia unit and had a history of falls and two recent strokes since his admission on 11/25/09. On 1/2/10 at 3 PM nurses notes and a post fall evaluation form indicated the resident fell from his wheelchair to the floor in the dayroom. Review of statements and interviews with staff revealed that although staff were in the area for the change of shift report no one actually saw the resident fall from the wheelchair. Nurse (E13) revealed that the resident was positioned in such a way that it did not appear the resident had hit his head. No neurochecks were started at that time. 2. R104 had unwitnessed falls from the bed and was found on the floor on 11/15/09 and 12/23/09. No neurochecks were initiated for these unwitnessed falls which may have involved the resident hitting his head. The facility's policy for neurological monitoring indicated that the purpose was to assess a resident with head trauma or suspected head	F 281	**F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (#1 & #2)** A. No immediate corrective action was able to be done. B. All residents have the potential to be affected by unwitnessed falls. C. Policy #1001 'Neurological Monitoring' was reviewed, revised and inserviced. Policy was implemented on 2/8/10. Memo was sent to all head nurses on 2/25/10 to disseminate to their staff that neurochecks must be initiated for all unwitnessed falls. CQI's event audit tool was revised to check that neurochecks are initiated when needed for falls. D. Falls are monitored by Hospital Quality Assurance nurse and CQI nurses. CQI nurses will randomly audit falls to ensure that neurochecks are initiated when appropriate.	3/25/10

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F 281	Continued From page 11 trauma. The facility updated their policy effective 2/8/10 to include in the purpose section "subsequent to an unwitnessed falls". 3. Cross refer F309. The facility failed to ensure that the pain management protocol for R31 met the professional standards of clinical practice as defined by the American Geriatrics Society. In particular, the facility failed to notify the physician of the new onset of right shoulder pain and failed to record a pain assessment in a way that facilitated regular reassessment.	F 281	**F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (#3)** A. Physician was notified on 2/12/10 of right shoulder pain. An x-ray was ordered and Banalg was ordered QID x 1 week for pain relief. B. All residents have the potential to be affected by this practice. C. Policy #319 'Physician Notification of Change' will be reviewed and revised as needed to include notifying physician when resident reports new onset of pain. Inservicing will be completed by April 30, 2010. IDCC worksheet will be reviewed and revised to include any new onset of pain. Policy #309 will be reviewed and revised as needed to include assessing pain for each resident q shift. Inservicing will be completed by April 30, 2010. D. Pain MAR will be reviewed by head nurse or designee for acceptable level of pain. If above acceptable level, physician will be notified. Head nurse or designee and CQI will randomly audit for pre and post pain medication assessments.	4/30/10
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, interviews, observation and review of facility's policy it was determined that the facility failed to provide care and services necessary to ensure adequate pain relief for one (R31) out of 25 residents. It was determined that the facility failed to notify the physician of the new onset of right shoulder pain experienced by R31 which resulted in the physician's inability to evaluate the appropriateness of the pain medication the resident received. In addition, failed to reassess the pain and failed to monitor	F 309		

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F 309	Continued From page 12 the effectiveness of R31's pain management intervention. Findings include: R31 was originally admitted to the facility on 11/17/1998 with diagnoses including cerebrovascular accident with left hemiparesis, peripheral neuropathy of left lower extremity, and chronic pain syndrome. The quarterly Minimum Data Set (MDS) assessments dated 7/9/09 and 10/8/09 noted R31 was only cognitively impaired in new situations and experienced mild pain less than on a daily basis. The most recent quarterly MDS dated 1/7/10 noted R31 experienced pain less than daily basis with moderate intensity. Review of the facility ' s policy titled " Pain Management " indicated a systematic and continuous approach will be utilized to monitor the effectiveness of pain through appropriate pain assessment and pain management at a level acceptable to the resident. Procedures included for significant change in pain, that a "Pain Assessment Tool" would be completed and that the physician would be notified. In addition, a "Pain Medication Administration Record (MAR)" would be utilized to document the pain assessment prior to and after administration of pain medication. Lastly, at the Interdisciplinary Care Conference (IDCC), the effectiveness of the pain management program will be evaluated based on the documentation from the Pain MAR and Pain Assessment tool. Review of the annual pain assessment dated 4/11/09 indicated R31 was experiencing pain of his left ankle due to a fracture and could verbalize pain on a scale of 0-5 and R31's acceptable level of pain was "1." The most recent pain assessment dated 1/11/10 documented that the	F 309	**F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING (#2 & #3)** A. Transcription of orders was immediately corrected. B. All residents have the potential to be affected by this practice. C. Policy #1704 'Medication/Treatment Orders: Transcribing and Discontinuing' will be reviewed and revised as needed to ensure physician's orders are transcribed to the appropriate document. D. Interim Physician's orders will be reviewed daily to ensure all new orders are addressed and transcribed correctly. Recheck physician's orders will be reviewed q 30-60 days depending on resident's level of care.	2/1/10 4/30/10

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F 309	Continued From page 13 resident experienced pain due to peripheral neuropathy of the legs. A care plan for alteration in comfort related to back and left side of body implemented on 10/20/06 included that the resident will report pain at acceptable level. Interventions included staff will determine the current level of pain in reference to an acceptable level of pain by use of the verbal pain scale. In addition, to notify physician when acceptable level of pain relief is not maintained. Review of the MAR for December 2009 revealed new onset of right shoulder pain with intensity of "3" or "4" (on a scale of 0-5) for which R31 was medicated with Percocet (a narcotic pain medication to treat moderate pain) 5 mg. by mouth for a total of seven doses out of the total 13 doses. On 12/30/09 at 5:45 PM, R31 reported pain at "4" and after the Percocet was given, R31 reported pain of "2", however, there was no evidence that the physician was notified of this level of pain in a new location. Review of January 2010 MAR indicated that R31 continued to experience pain in the right shoulder with the majority at the moderate intensity ("3") in which R31 was medicated with Percocet 5 mg. by mouth for total of 12 doses out of the total 21 doses. Of the 12 complaints of right shoulder pain and administration of Percocet, there was no reassessment for seven of the doses. On 1/18/10 at 9:45 PM, R31 reported pain at "5" prior to Percocet, however, there was no evidence of an reassessment. During an interview with R31 on 2/9/10 at approximately 9 AM, R31 reported right shoulder	F 309		

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F 309	Continued From page 14 pain with intensity of "2". An interview with the head nurse (E14) on 2/9/10 at approximately 1:30 PM revealed that she was not aware of this new onset of pain. Subsequent to this interview, a pain assessment tool was completed for the right shoulder pain and revision to the above care plan. The current pain management standards by the American Geriatrics Society includes: - appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management. Above findings were reviewed with administration on 2/12/10 at approximately 3 PM. An interview with R31's attending physician (E19) on 2/15/10 at approximately 9 AM confirmed that she was not notified regarding R31's complaints of pain in the right shoulder until this survey. E19 further related that x-ray of the right shoulder completed on 2/12/10 revealed mild arthritis, thus, Percocet would not be an acceptable medication for treatment and that Banalg arthritis topical cream four times per day for one week will be utilized to address the arthritic pain. Although R31 experienced new onset of right shoulder pain beginning in December 2009, the facility failed to notify the physician, reassess and monitor the effectiveness of these interventions as it related to resident's goals and current	F 309		

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F 309	Continued From page 15 standards of practice. 2. On 1/11/10 the physician wrote an order for Banalg cream to muscles and joints as needed four times a day for R214. The January and February 2010 treatment and medication records were reviewed as well as CNA treatment records. No CNA treatment could be found. An interview with the unit secretary (E15) on 2/5/10 and unit manager (E14) revealed they could not find the treatment record for this order. An interview with a 3-11 aide (E16) on 2/5/10 revealed that she could not find the use of the Banalg cream order in the CNA book but believed it was kept at the bedside for the aides on dayshift to use. An interview with R214 on 2/12/10 revealed that the Banalg was in her nightstand drawer and that at times an aide on 11-7 shift has put it on her leg where it hurts. There was no evidence that all CNA staff knew the cream was in use. There was no documentation to determine how frequently the resident requested the cream or if it was effective. 3. Review of R7's 1/10 and 2/10 TARs (Treatment Administration Record) revealed a physician's order, dated 1/13/09, that stated, "Banalg Cream (arthritic pain reliever) to LT (Left) arm/shoulder 4 (four) times a day and PRN (as needed)." During an interview on 2/2/10 at 3:55 PM, E17, a nurse, confirmed that the Banalg cream was to be administered at least 4 times a day, and more as needed. Review of the 1/10 and 2/10 TARs revealed that while the order itself was	F 309		

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F 309	Continued From page 16 transcribed correctly, the "times" were not correctly transcribed. The TARs listed the times only as "PRN". The 1/10 and 2/10 TARs lacked evidence that the treatment had been administered at least 4 times a day. During an interview on 2/2/10 at 5:10 PM, E18, the nursing supervisor, acknowledged that the Banalg cream was "not given as ordered, " since the times had not been properly transcribed on the TARs. She then rewrote the Banalg Cream order and timed it for 8:30 AM, 12:30 PM, 4:30 PM, 8:30 PM and "prn" and stated that she would alert the nursing staff.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined that for one (R104) out of 25 residents the facility failed to ensure that assistance devices were provided to prevent accidents and injuries. Findings include: 1. R104's MDS assessments dated 9/16/09 and 12/16/09 indicated a history of falls, limited assistance with one person assist for transfers, independent with locomotion in a wheelchair and did not ambulate in the room.	F 323		

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F 323	Continued From page 17 A post fall evaluation form dated 11/15/09 documented at 4:05 AM resident took off his gown which had a tag alarm attached to it and was found on floor next to bed called by roommate for assist no injuries. Under 'special problem' staff documented "bed can't crank down to lowest position". No neuro checks were initiated. A nurse's note dated 12/23/09 and timed 2:55 AM documented "roommate yelled for staff that patient had fallen off his bed. Staff rushed there to find patient on the floor in front of his bed no injury noted. Tab alarm still ringing". No neurochecks were initiated. R104's physician order sheet (POS) for November 2009 and January 2010 indicated the resident was to have an ultra low bed. This approach of a low bed to decrease risk of injures with falls was not added to the care plan. Observation of the room on 2/9/10 revealed a bed that was about 24 inches off the floor. An interview with E4 (aide) revealed that this was not a low bed. She attempted to crank the bed down further and it would not go down. E4 took the surveyor to another room to see a "low bed" that went down to about 6 inches from the floor. The resident with the ultra low bed also had a mat in the room that staff put next to the bed when the resident is in bed. There was no mat in R104's room. An interview with the unit manager (E4) revealed that she thought the resident had a low bed at one time but it broke. She further revealed that there was a shortage of low beds and she thought there was an order to discontinue the low bed. No	F 323	**F323 FREE OF ACCIDENT HAZARDS/SUPERVISION DEVICES** A. Ultra low bed was provided for Resident #104 and the care plan was updated to reflect this. B. All residents have the potential to be affected by this practice. C. IDCC worksheet will be reviewed and revised to include interventions to prevent falls (i.e. mats, alarms, ultra low or low bed). Policy #1704 'Medication/Treatment Orders: Transcribing and Discontinuing' will be reviewed and revised as needed to ensure physician's orders are addressed in the care plan as needed. Policy #1001 'Neurological Monitoring' was reviewed, revised and inserviced. Policy was implemented on 2/8/10. Memo was sent to all head nurses on 2/25/10 to disseminate to their staff that neurochecks must be initiated for all unwitnessed falls. CQI's event audit tool was revised to check that neurochecks are initiated when needed for falls. D. Interim Physician's orders will be reviewed daily to ensure all new orders are addressed and care planned for appropriately. Recheck physician's orders will be reviewed q 30-60 days depending on resident's level of care. CQI nurses will randomly audit falls to ensure that neurochecks are initiated when appropriate.	2/25/10

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F 323	Continued From page 18 order to discontinue the low bed could be found. R104 had two falls from his bed to the floor. The approach added to the plan of care for an ultra low bed was not implemented.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	**F441 INFECTION CONTROL, PREVENT SPREAD, LINENS** A. Head nurse discussed with employee hand washing practices in relation to medication administration. B. This was an isolated incident. C. Inservicing regarding infection control practices while administering medications will be provided to nursing staff and completed by April 30, 2010. D. Random audits of infection control practices while administering meds will be conducted by Staff Development and/or Infection Control nurse. Implementation of IC practices while administering medications education will be reviewed in Nursing Orientation.	4/30/10

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F 441	Continued From page 19 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and review of other facility documents, the facility failed to provide a safe, sanitary, and comfortable environment, to prevent the development and transmission of disease and infection. One staff failed to wash her hands after picking up a dropped pill from the floor with her bare hand. Findings include: The facility's policy number 209, "Employee Hand Washing," was reviewed. During the med pass observation on 2/3/10 at 9:20 AM, E24, a nurse dropped a B12 (Vitamin) pill on the floor, then picked it up with a bare hand and threw it away. Without handwashing or donning gloves, E24 continued to prepare another B-12 pill. She poured out 2 pills in the bottle cap of a stock medication and used the right index finger of her ungloved, unwashed, contaminated hand to manually push one pill into the paper medication cup. She continued preparing the medications and administered them to R174. During an interview on 2/3/10 at 9:50 AM, E24 acknowledged that she should have washed her hands and not touched pills with her bare contaminated finger. During an interview on 2/3/10 at 1000, E25, the head nurse, agreed that E24 should have washed her hands after the	F 441		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 20 B-12 pill dropped, before continuing with the medication preparation and administration.	F 441		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview it was determined that the facility failed to maintain a quality assessment and assurance committee that met quarterly consisting of the physician designated by the facility. Findings include:	F 520	**F 520**: QAA Committee-Members/Meet Quarterly/Plans A. The Medical Director was made aware of her responsibility to attend the Quality Assurance Committee meetings quarterly. **Completion Date**: 2/12/10 B. All residents have the potential to be affected by this deficient practice. If the Medical Director is unavailable and/or cannot participate in the Quality Assurance Committee meeting, a designated physician will be appointed. **Start Date**: April 23, 2010 **Completion Date**: Ongoing C. The Quality Assurance Committee will continue to meet quarterly during the months of January, April, July, and October. **Completion Date**: Ongoing D. The Quality Assurance Department will provide the Medical Director with minutes and an agenda one week prior to the scheduled quarterly meeting date to ensure a physician is present. **Completion Date**: Ongoing	4/23/10

PRINTED: 02/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085035	A. BUILDING _____ B. WING _____	C 02/12/2010

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F 520	Continued From page 21 An interview with the quality assurance administrator (E8) on 2/12/10 at 9:45 AM revealed that the physician designated by the facility failed to attend three consecutive quarterly meetings held on 7/23/09, 10/22/09, and 1/21/10. The facility continued to conduct quarterly quality assurance meetings without the designated physician present.	F 520		

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Delaware Hospital for the Chronically Ill

DATE SURVEY COMPLETED: February 12, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An annual survey and complaint visit was conducted at the facility from January 27, 2010 through February 12, 2010. The deficiencies contained in this survey are based on observations, interviews, review of residents' clinical records, and review of other facility documentation as indicated. The survey sample included sixteen (16) admission and thirty (30) census residents in Stage I. The Stage II sample included twenty-five (25) residents.	
3201	**Regulations for Skilled and Intermediate Care Nursing Facilities**	
3201.6.1	**General Services**	
3201.6.1.1	**The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.** **This requirement is not met as evidenced by:**	

Provider's Signature Cheryl A Hollis Title Acting Director NHA Date 03-15-10

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	Cross-refer to CMS 2567-L survey date completed 2/12/2010, F157, ~~F225, F253~~, F281, F309, F323 and F441.	Cross-Refer F157, F281, F309, F323, F441.
3201.6.5	**Nursing Administration**	
3201.6.5.7	**The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/12/2010, F280.	**F280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP** A. Ultra low bed was provided for Resident #104 and the care plan was updated to reflect this. B. All residents have the potential to be affected by this practice. C. IDCC worksheet will be reviewed and revised to include interventions to prevent falls (i.e. mats, alarms, ultra low or low bed). Policy #1704 'Medication/Treatment Orders: Transcribing and Discontinuing' will be reviewed and revised as needed to ensure physician's orders are addressed in the care plan as needed. D. Interim Physician's orders will be reviewed daily to ensure all new orders are addressed and care planned for appropriately. Recheck physician's orders will be reviewed q 30-60 days depending on resident's level of care. Completion Date: 4/30/10
3201.6.6.1	**The nursing facility's activities program shall provide diversified individual activity plans and group activities for each resident based on the comprehensive assessment as well as an activity assessment conducted by the activity director. The activities offered shall reflect the needs, interests, abilities, preferences, limitations and age of each**	

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	resident. **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/12/2010, F248.	F248: ACTIVITIES MEET INTERESTS/NEEDS EACH RESIDENT A. Resident 194's Care Plan was immediately reviewed and the annual Activity Assessment, which is due in April, was completed and updated to reflect the resident's current capabilities, interests, and needs. To assure that Nursing Staff on the units are aware of the Activity Plan, the Resident Profile was revised and now allows for an "Activity Interest" section which summarizes Resident 194's Activity interests. Lastly, Activity Staff have been re-inserviced on the best practices to follow to capture as many resident interactions and activity participation units on their monthly Activity documentation form. Completion Date: March 11, 2010 B. All residents have the potential to be affected by the same deficient practices. Therefore, all Residents' Profiles will be revised to include a Residents' Interest section which summarizes their Activity Care Plan information. Activities staff will write the summaries and share with the appropriate staff for completion. In addition, the Activity Summaries will be posted on the inside of each Residents' closet for review by staff to increase their accessibility and knowledge of each Resident's Activity Plan. Completion Date: May 14, 2010 C. To assure that the Resident Profiles are updated to coincide with the Care Plans, the Activity Interest section will be completed and reviewed at each Resident's IDCC Meeting. It will be the Activities Staff responsibility to assure all updates have been addressed in each Care Plan and Activity Summaries are posted in Resident Rooms. D. Monitoring the completion of Resident Profile Forms and Resident Room Activity Summaries will be the responsibility of the Activity Therapy Department to report to the Quality Assurance Committee. Under the direction of the Director of Rehabilitation and the Activities Coordinator each quarter, random audits will be performed and documented. All findings will be reported at each quarterly meeting to assure compliance.
3201.6.9 3201.6.9.1	**Housekeeping and Laundry Services** **The facility shall employ sufficient housekeeping personnel and provide the necessary equipment to maintain a safe, clean, and orderly environment, free from offensive odors, for the interior and exterior of the facility.** **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/12/2010, F253.	F 253: Housekeeping & Maintenance Services A. 1. Work order request for Rm. 253 to repair paint damages around the window area has been submitted. Actual repair work follows. **Completion Date: 3/20/10** The missing drawer was replaced. **Completion Date: 2/15/10** 2. The bedside stands in Rooms 266, 260, and 306 (total of four) will be replaced. Completion Date: **3/10/10** The four bedside stands from Room 266, 260, and 306 will be evaluated by Facility operations for repair or replacement. **Completion Date: 3/20/10** 3. Work order request for wall plaster and paint damages in Rooms 308 and 366 has been submitted. Actual repair work follows. **Completion Date: 3/20/10** 4. Work order request to repair wall damage in Room 304 has been submitted. Actual repair works follows. **Completion Date: 3/20/10**
3201.9 3201.9.1	**Quality Assessment and Assurance** **Each facility shall have a quality assessment and assurance committee which shall include the director of nursing, a physician and at least 3 other members of the facility's staff.** **This requirement is not met as evidenced by:**	

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	Cross-refer to CMS 2567-L survey date completed 2/12/2010, F520.	F 253: Housekeeping & Maintenance Services (continued) B. A sweep of the Nursing Units where problem areas has been identified was completed on 3/8/10. Steps are being taken to repair or replace damaged night stands. Steps are also being taken to repair wall paint or plaster damages in resident rooms. **Completion Date : 3/20/10** C. Charge Nurses will submit work orders, via e-mail, to Facility Operations as repair needs are identified in their respective Nursing Unit. **Completion Date: On-going** D. A Risk Manager, of Quality Assurance, will perform random on-going inspections of resident rooms to ensure compliance under this requirement. **Completion Date: On-going**
3201.10.6	**All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long Term Care Residents Protection. Telephone number: 1-877-453-0012; fax number: 1-877-264-8516.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L, survey date completed 2/12/09, F225.	F 520: QAA Committee-Members/Meet Quarterly/Plans A. The Medical Director was made aware of her responsibility to attend the Quality Assurance Committee meetings quarterly. **Completion Date: 2/12/10** B. All residents have the potential to be affected by this deficient practice. If the Medical Director is unavailable and/or cannot participate in the Quality Assurance Committee meeting, a designated physician will be appointed. **Start Date:** April 23, 2010 **Completion Date:** Ongoing C. The Quality Assurance Committee will continue to meet quarterly during the months of January, April, July, and October. **Completion Date:** Ongoing D. The Quality Assurance Department will provide the Medical Director with minutes and an agenda one week prior to the scheduled quarterly meeting date to ensure a physician is present. **Completion Date:** Ongoing
16 Del. C, Chapter 11, Sub Chapter II, §1121	**Patient's Rights (6)** **Each patient and resident shall receive respect and privacy in the patient's or resident's own medical care program. Case discussion, consultation, examination and treatment shall be confidential, and shall be conducted discreetly. In the patient's discretion, persons not directly involved in the patient's care shall not be permitted to be present during such discussions, consultations, examinations or**	F 225 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS A Upon receiving the incident report detailing the information pertaining to the allegation of neglect in relation to R137, the QA Department immediately reported the incident as a PM-46 to LTCRP and an investigation was initiated. B PM-46 training is conducted annually and reporting of PM-46 incidents is covered during the training session. In addition, during November and December of 2009, a series of training sessions were held specifically focused on the Incident Reporting process with a strong emphasis on the importance of immediate notification. The incident report training will be held annually or more often as needed and during orientation of new employees in concert with the PM46 instruction. C Nurse E6 was reminded on 7/31/09 of her responsibility to report any incident that may meet PM-46 standards and the importance of turning in incident reports immediately. D To remedy the potential of incidents in the future an incident report committee was formed to address improving DHCI's incident reporting process and to improve staff involvement in immediate reporting. The committee met on January of 2010 and is scheduled meet monthly up to May 14, 2010. Furthermore, a meeting will be scheduled with all department heads no later than April 16, 2010 to discuss and relay concerns to be shared with related staff. In addition, Quality Assurance monitors the 24 hour reports and Incident Reports on a daily basis. Upon discovery of an incident that was not reported, they will follow-up to ensure an Incident Report is written, and the process is followed for PM-46 reporting.

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	treatment, except with the consent of the patient or resident. Personal and medical records shall be treated confidentially, and shall not be made public without the consent of the patient or resident, except such records as are needed for a patient's transfer to another health care institution or as required by law or third party payment contract. No personal or medical records shall be released to any person inside or outside the facility who has no demonstrable need for such records. **This requirement is not met as evidenced by:** Cross-refer to CMS 2567-L survey date completed 2/12/2010, F164.	F164 PRIVACY AND CONFIDENTIALITY (#1) A. Privacy curtain was immediately pulled for Resident #54. B. All residents have the potential to be affected by this practice. C. Head nurse or designee will in-service staff regarding the importance of maintaining the confidentiality, dignity and privacy of each resident. In-servicing will be completed by April 30, 2010. D. Random unit rounds will be conducted during each shift by the head nurse or designee as well as the nursing supervisors. F164 PRIVACY AND CONFIDENTIALITY (#2 & #3) A. Signs were removed immediately from resident's room and discarded so not to be used again in facility. B. A sweep of all residents on Contact Precautions was conducted to ensure that other Contact Precaution signs were not circled indicating specifics about their diagnosis. C. Contact Precaution Policy will be reviewed for clarity of procedures. Education will be completed on Personal Privacy/Confidentiality of records and how it relates to residents when they are placed on "Special Precautions –Contact Precautions" by April 30, 2010. D. Infection Control Nurse or designee will visit all residents initially placed on Special Precautions and ensure proper Infection Control processes and Special Precautions procedures are in place. Routine rounds will be conducted on all Residents on Special Precautions. Random audits will be conducted on residents placed on Special Precautions.